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FAST Plus Strategy for TB Control in Selected Luzon Health Facilities: A GPPI Landscape Report

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ACRONYMS AND OTHER ABBREVIATIONS

BCC	behavior change communications
CLAIMHealth	Collaborating, Learning, and Adapting for Improved Health
DOH	Department of Health
DSSM	direct sputum smear microscopy
ENHANCE	Enhancing Hospital Networks and Communities to End TB
FAST	Finding TB Cases Actively, Separating Safely, and Treating Effectively
FAST Plus	Integration of the ENHANCE and FAST strategies for TB detection and prevention
HCW	health care worker
HP	Health Project, USAID/Philippines
GPPI	good practices and promising interventions
IP	implementing partners
IPC	infection prevention and control
ITIS	Integrated TB Information System
KII	key informant interviews
LGU	local government unit
MOP	Manual of Procedures
NCR	National Capital Region
NTP	National Tuberculosis Control Program
OH	Office of Health, USAID
PPE	personal protective equipment
STRiders	Specimen Transport Riders
TB	tuberculosis
TB DOTS	TB directly observed treatment, short-course
TB-LAMP	TB loop-mediated isothermal amplification platform
TB Platforms	TB Platforms for Sustainable Detection, Care, and Treatment
TBIHSS	TB Innovations and Health Systems Strengthening
UHC	universal health care
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

Tuberculosis (TB) is a major public health issue in the Philippines. The country's 2016 National TB Prevalence Survey estimated an incidence of 554 cases per 100,000 persons and a prevalence rate of 1 million active TB cases. In response, the Philippines government pledged to find and treat 2.5 million missed TB patients between 2017 and 2022. This will contribute to the National Tuberculosis Control Program's (NTP) goal of reducing TB mortality by 95 percent and TB incidence by 90 percent by 2035.

In 2018, USAID/Philippines's Office of Health (OH) launched the TB Innovations and Health Systems Strengthening Project (TBIHSS), and TB Platforms for Sustainable Detection, Care, and Treatment (TB Platforms). Both activities developed targeted strategies to accelerate achievement of NTP's goals and USAID's TB Roadmap—TBIHSS created *Enhancing Hospital Networks and Communities to End TB* (ENHANCE) and TB Platforms introduced *Finding TB Cases Actively, Separating Safely, and Treating Effectively* (FAST).

TB Platforms and TBIHSS integrated their two strategies into a single strategy known as FAST Plus. OH's TB Cluster, which TB Platforms and TBIHSS are both members of, agreed that a coordinated and integrated strategy like this would streamline work processes and enhance the capabilities of engaged hospitals in providing TB services. NTP also sought integration of FAST and ENHANCE as a way of streamlining USAID's technical assistance for TB. FAST Plus is thus an integrated hospital engagement strategy for systematic screening, diagnosis, treatment, prevention, and notification of patients with TB. It aims to strengthen and maximize the outcomes of multiple services along the TB continuum of care through three essential features:

1. Systematic screening, testing, and treatment at points of care
2. Infection prevention and control measures in hospitals
3. Use of a hospital notification system for TB.

Since 2019, TBIHSS and TB Platforms have introduced FAST Plus in 301 health facilities in the National Capital Region (NCR), Region III, and Region IV-A. Inasmuch as OH has encouraged its implementing partners to document good practices and promising interventions (GPPIs) as a way of promoting replication and scale-up, the rich experience from implementing FAST Plus in hospitals deserves continuous documentation as a good practice in and of itself.

Objective and learning questions

Documenting the FAST Plus strategy as a potential GPPI is meant to determine if it has led to improved TB control outputs and outcomes across the continuum of care. This documentation effort is guided by 13 learning questions that are clustered into five major domains:

1. Alignment and compliance with international standards and local FAST Plus guidelines
2. Adaptive management and lessons learned
3. Contribution to health outputs and outcomes
4. Replicability

5. Systems and contexts

This documentation also uses seven GPPI criteria that USAID's Collaborating, Learning, and Adapting for Improved Health (CLAimHealth) promotes: effectiveness, replicability, commitment, alignment, integration, inclusiveness, and resources.

Methodology

This publication is a preliminary report that lays the foundation for continuous documentation of the FAST Plus strategy by TB Platforms and TBIHSS through 2024. For this first phase of documentation (December 2021 to January 2022), CLAimHealth collaborated with TB Platforms and TBIHSS to review reports and documents, conduct online surveys, and conduct key informant interviews. We purposely selected 10 hospitals and one public health center from the USAID-supported regions that have the highest TB burden: NCR, Region III, and Region IV-A. We then collected data remotely due to community quarantine restrictions during the COVID-19 pandemic.

Results

We present the results according to the five domains that encompassed the learning questions.

1. Alignment and compliance with international standards and local FAST Plus guidelines

FAST Plus is aligned with the NTP Manual of Procedures, sixth edition. Including the pediatric age group for TB screening in the Philippines is a FAST Plus element that is similar to global FAST practices (e.g., in Bangladesh, Vietnam, Nigeria, and Georgia). Of the eight facilities that participated in our online survey, two (one public and one private level-3 hospital) answered 'yes' to all 11 statements/practices on TB standards of care, thus demonstrating the highest level of compliance with local FAST Plus models. Although all of the health facilities we surveyed complied with the first four statements/practices on TB standards of care, they had varying levels of compliance with the others. Having supportive policies and designated health providers for the intervention—even entire units or departments—were also indications of health facilities' compliance with FAST Plus.

2. Adaptive management and lessons learned

a. Behavior change communications and advocacy

Key behavior change and advocacy actions influenced clients/patients to seek x-ray screening and enroll in treatment, including:

- Counseling and health education
- Regular communication, training activities, and promotion of FAST Plus elements in hospitals
- Posters
- One-on-one counseling
- Social media posts, virtual chat rooms, and Zoom orientation
- Home visits
- Free chest X-ray vouchers
- Forums with clients/patients

b. Enabling and hindering factors

The primary factors that led health facilities to adopt FAST Plus were:

- A desire to receive technical assistance from OH's implementing partners
- A desire to improve their knowledge about TB care
- Supportive local chief executives and hospital administrations
- A desire to contribute to the NTP's goals
- The opportunity to obtain free medicine for treating TB patients
- The availability of diagnostic facilities such as Xpert MTB/RIF and direct sputum smear microscopy

Factors hindering the adoption and continuation of FAST Plus in health facilities were:

- Poor compliance of doctors to standards of care
- Lack of trained human resources
- Increased resignations during the early days of the COVID-19 pandemic
- Poor data management and referral systems
- Fake information from some TB patients
- Weak internet connections
- The long duration of TB treatment
- Insufficient financial support for patients

c. COVID-19 impacts and adaptations

The beginning of the COVID-19 pandemic led to key effects in health facilities:

- Hospitals were overwhelmed and forced to shift resources to COVID-19 response.
- TB patients were hesitant or did not visit health facilities for fear of getting infected with the virus.
- There was limited interaction with TB patients who were admitted to the hospital because they were placed with COVID-19 patients.
- Services in level-I health facilities were temporarily suspended.

Level-3 health facilities sustained operations through adaptive actions and by conducting online capacity building activities for their TB staff. Common adaptive actions were:

- Merging TB and COVID-19 screening forms
- Separating TB patients based on their COVID-19 status
- Using online services like telemedicine
- Administering COVID-19 and TB questionnaires to patients at all entry and exit points
- Assigning dedicated rooms for TB cases
- Requiring personal protective equipment during TB screening

3. Contribution to health outputs and outcomes

Performance statistics showed significant drops in the number of patients for TB screening, testing, treatment, and notification during the first two years of the COVID-19 pandemic. However, the turnaround time at every phase of the continuum of care remained the same (from 2 to 7 days) for the entire period between 2019 and 2021. Low outputs from the health facilities despite FAST Plus implementation can be attributed mainly to the long lockdown and people's fear of acquiring COVID-19 from hospital visits.

4. Replicability

The key factors that will influence the replicability of FAST Plus in sites beyond current facilities are:

- Direct promotion of the intervention by the DOH NTP
- Enactment of an NTP-supportive policy to launch and sustain FAST Plus
- Provision of all referring facilities with Xpert and a sputum transport mechanism
- Full use of the Integrated TB Information System for timely referrals
- Establishment of referral networks that are linked with the country's Universal Health Care program
- Investment in the training of TB care providers
- Identification of TB champions.

5. Contexts and systems

Successful implementation of FAST Plus requires:

- Strong support from hospital administrations and local government units
- A clear government policy for implementation
- Tele-contact investigation
- TB preventive therapy
- Financing in the context of UHC
- Data privacy
- Reimbursements through PhilHealth
- Better coordination between hospitals, rural health units, and provincial governments

Conclusion and Recommendations

The evidence collected in this landscape analysis of 11 public and private health facilities that provide different levels of health care suggests that the FAST Plus strategy meets five of the seven GPPI criteria: commitment, alignment, integration, inclusiveness, and resources. Thus, FAST Plus is a promising intervention. Evidence of its effectiveness and replicability will need to be demonstrated in the remaining years of TB Platforms and TBIHSS. The two TB implementing partners that have been providing technical assistance to many health facilities in the Philippines' "big three" TB regions believe that FAST Plus has the potential to be replicable and sustainable, but this largely depends on its direct promotion and championing by the DOH NTP, LGUs, and hospital administrations; and the establishment of referral networks and improved health financing as part of the UHC Law.

This initial documentation and landscape analysis lays the groundwork for more robust GPPI documentation of FAST Plus. It should lead to joint documentation by TB Platforms and TBIHSS. Both implementing partners have the reach and presence on the ground to obtain more complete data on

effectiveness from all health facilities implementing FAST Plus as well as the processes that facilitate or hinder successful implementation.

We recommend a common GPPI documentation protocol, regular exchange and consolidation of information and data through the OH TB Cluster meetings, and joint pause-and-reflect sessions. We also recommend related research studies to enhance and accelerate FAST Plus implementation throughout the country such as:

- Implementation research comparing FAST Plus implementation at different levels and in different types of health facilities
- Case studies of the health facilities that are most and least compliant with FAST Plus guidelines
- Assessment of the technical assistance that OH's implementing partners provide for FAST Plus
- Comparison of FAST Plus and non-FAST Plus health facilities
- A study of the roles played in FAST Plus by other stakeholders and of their contributions. Such stakeholders should include DOH NTP, LGU officials, PhilHealth, professional and other civil society organizations, and TB patients.

I. BACKGROUND

I.1. GOOD PRACTICES AND PROMISING INTERVENTIONS

Collaborating, Learning, and Adapting for Improved Health (CLAimHealth) provides monitoring, evaluation, and learning support to the U.S. Agency for International Development (USAID)/Philippines' Health Project (HP) (2018–2024), which seeks to improve health outcomes for underserved Filipinos. CLAimHealth, one of nine ongoing activities in USAID's HP, generates and uses high-quality monitoring and evaluation data, documents good practices and promising interventions (GPPIs), and conducts implementation research. With respect to GPPI, a good practice is defined as an intervention, technology, or methodology that, through rigorous peer review and evaluation, clearly links positive effects to the practice, has been shown to be effective in a specific city or province, and can be replicated. A promising intervention, on the other hand, has strong quantitative and qualitative data showing positive outcomes but does not yet have enough evidence to support generalizable positive health outcomes and the potential for scale-up.

The context, process, and outcomes of these interventions should be assessed according to standard criteria. Namely, a good practice or high-impact intervention should meet most, if not all, of the following seven evaluation criteria: effectiveness, replicability, commitment, alignment, integration, inclusiveness, and resources.^{1, 2, 3} Their effectiveness should be linked to the achievement of goals of the USAID Office of Health (OH) and the HP's high-level indicators. For the duration of its contract (2018–2022), CLAimHealth has identified and documented potential GPPIs of previous and current USAID OH implementing partners (IPs). This documentation is designed to validate whether the recommended interventions are indeed GPPIs that should be replicated and scaled up nationally. This landscape report is the ninth in a technical series of selected GPPIs documented over the life of the HP. This initial GPPI documentation process lays the groundwork for assessing FAST Plus, a health-specific intervention introduced by the USAID Philippines OH to accelerate detection of persons with tuberculosis (TB) and prevent the spread of TB. FAST Plus, which is aligned with the Department of Health's (DOH's) National TB Control Program (NTP), is the integration of two strategies: FAST (Finding TB Cases Actively, Separating Safely, and Treating Effectively) and ENHANCE (Enhancing Hospital Networks and Communities to End TB), both of which aim to improve the capacity of participating health facilities, particularly hospitals' capability in providing good-quality TB services, specifically in screening, detection, notification, treatment, and prevention.

¹ Eileen Ng and Pierpaolo de Colombani, "Framework for Selecting Best Practices in Public Health: A Systematic Literature Review," *Journal of Public Health Research* 4, no. 3 (November 2015), <https://doi.org/10.4081/JPHR.2015.577>.

² Bridgit Adamou et al., "Guide for Monitoring Scale-Up of Health Practices and Interventions," *MEASURE Evaluation Population and Reproductive Health*, January 2014, https://www.measureevaluation.org/resources/publications/ms13-64/at_download/document.

³ World Health Organization, "A Guide to Identifying and Documenting Best Practices in Family Planning Programmes," 2017, <http://apps.who.int/bookorders>.

1.2. TB IN THE PHILIPPINES AND THE USAID HP RESPONSE

TB continues to be a significant public health problem in the Philippines. The 2016 National TB Prevalence Survey estimated the prevalence rate of bacteriologically confirmed pulmonary TB to be 1,159 per 100,000 population aged 15 years and up,⁴ while the total TB incidence rate was 539 per 100,000 as of 2020.⁵ With this burden, the Philippine government committed to detecting and treating 2.5 million persons with TB by the end of 2022.⁶ This is consistent with the NTP's vision of a TB-free Philippines by 2035.

In the two years since the onset of the COVID-19 pandemic, access to TB care has been influenced by people's perception of the increased risk of acquiring COVID-19 when they leave their houses. In turn, this has caused delays or cancellations of appointments for TB consults, screening, and treatment. While FAST Plus was focusing on the TB care pathway, COVID-19 introduced unforeseen challenges and highlighted the need to adapt. The key features of FAST Plus are also in line with some approaches in managing COVID-19 cases in hospitals, such as testing, infection control, and case notification, albeit in a different digital platform; Integrated TB Information System (ITIS) is used for TB, and COVID-KAYA is used for managing data on COVID-19 cases and their contacts.

In February 2018, the OH launched one of its HP activities, the TB Innovations and Health Systems Strengthening Project (TBIHSS). In April 2018, the OH launched the second of its TB activities, TB Platforms for Sustainable Detection, Care, and Treatment (TB Platforms), which is being implemented by University Research Co., LLC. To accelerate the accomplishment of the NTP goals as well as USAID's TB Roadmap, TB Platforms and TBIHSS introduced their respective strategies for accelerating TB case detection and prevention, particularly in hospital settings: FAST and ENHANCE.

FAST, implemented by TB Platforms, is a strategy for preventing nosocomial TB transmission by detecting and treating confirmed cases of TB and multidrug-resistant TB promptly. FAST's critical milestones include: (1) cough surveillance and triage at the facility's entry point; (2) identification of presumptive TB cases; (3) counseling on the necessity of sputum testing; (4) consults for sputum production, specimen collection, and transportation; (5) result follow-up and notification; and (6) diagnosis and treatment initiation upon receipt of diagnostic results. TB Platforms implemented FAST in 22 Level 1 and Level 2 public and private hospitals and health centers in U.S. government-assisted regions: National Capital Region (NCR), Central Luzon (Region III), and CALABARZON (Region IV-A).

ENHANCE, implemented by TBIHSS, aims to strengthen hospital systems in order to provide high-quality, patient-centered TB care. This includes implementing hospital-based TB case notification processes through hospital system optimization. ENHANCE initially focused on 70 level-3 public and private hospitals in the NCR, Region III, and Region IV-A.

⁴ Mary Ann D. Lansang et al., "High TB Burden and Low Notification Rates in the Philippines: The 2016 National TB Prevalence Survey," *PLOS ONE* 16, no. 6 (June 2021): e0252240–e0252240, <https://doi.org/10.1371/JOURNAL.PONE.0252240>.

⁵ World Health Organization, *Global Tuberculosis Report 2021* (Geneva, Switzerland, 2021), <https://apps.who.int/iris/rest/bitstreams/1379788/retrieve>.

⁶ Department of Health et al., "Pledge of Support to the Accelerated Response to Meet the UN High Level Commitment to End TB in the Philippines," 2019.

TB Platforms and TBIHSS are members of the OH TB Cluster and the OH CLA Technical Working Group. These groups meet every other month to discuss performance monitoring and evaluation and CLA-related matters. The CLA Technical Working Group in particular focuses on strengthening partnership and coordination between and among the OH and the IPs. With similarities used in the FAST and ENHANCE strategies, albeit at different levels of the hospital system, the OH TB Cluster agreed that a coordinated and integrated strategy for TB screening, detection, treatment, and prevention would streamline work processes; enhance the technical and management capabilities of engaged hospitals in providing quality TB services, especially in screening, detection, treatment, and notification; and allow faster replication of the combined strategy. DOH NTP leadership likewise saw the need to integrate the FAST and ENHANCE strategies to streamline USAID's technical assistance.

This landscape analysis provides an overview of the FAST Plus model and analyzes the parameters for documenting the potential of the FAST Plus strategy as a GPPI against its implementation to date in the health facilities that have received technical support from the two TB IPs.

2. OVERVIEW OF FAST PLUS

2.1. CONCEPTUAL AND IMPLEMENTATION FRAMEWORKS OF FAST PLUS

FAST Plus is an integrated hospital engagement model that consolidates the strategies of two hospital engagement models for TB: ENHANCE and FAST. Through more systematic screening, rapid testing and notification, and efficient enrollment to TB treatment and care, FAST Plus aims to strengthen and maximize the outcomes of different services along the TB care continuum.

FAST Plus encompasses and emphasizes efficient triaging, early recognition and source control, access to rapid molecular TB diagnostics, patient-centered support, and the use of digital applications. It has three key features: (1) systematic screening, testing, and treatment at point of care; (2) infection prevention and control (IPC) strategies for hospitals; and (3) use of a hospital notification system for TB.

The HP implemented FAST Plus to promote safe IPC practices and patient-centered care that will sustain TB services from screening to notification during and beyond the COVID-19 pandemic. It can potentially be used as a model for detection and care of other infectious diseases. OH TB activity leadership also envisioned that through FAST Plus, TB care would be standardized through digital notification tools, rapid diagnostic testing, and private–public collaboration for patient-centered treatment support, regardless of hospital categorization.⁷

The HP TB activities operate in the “big three” regions with the country’s highest TB burden: the NCR, Region III, and Region IV-A. USAID introduced FAST Plus in selected health facilities in these regions using a conceptual and implementation framework illustrated in [Figure 1](#).

⁷ TB Innovations and Health Systems Strengthening, “Harmonizing Approaches for Hospital Engagement to Find, Treat & Notify TB ENHANCE to FAST Plus Approach,” 2020.

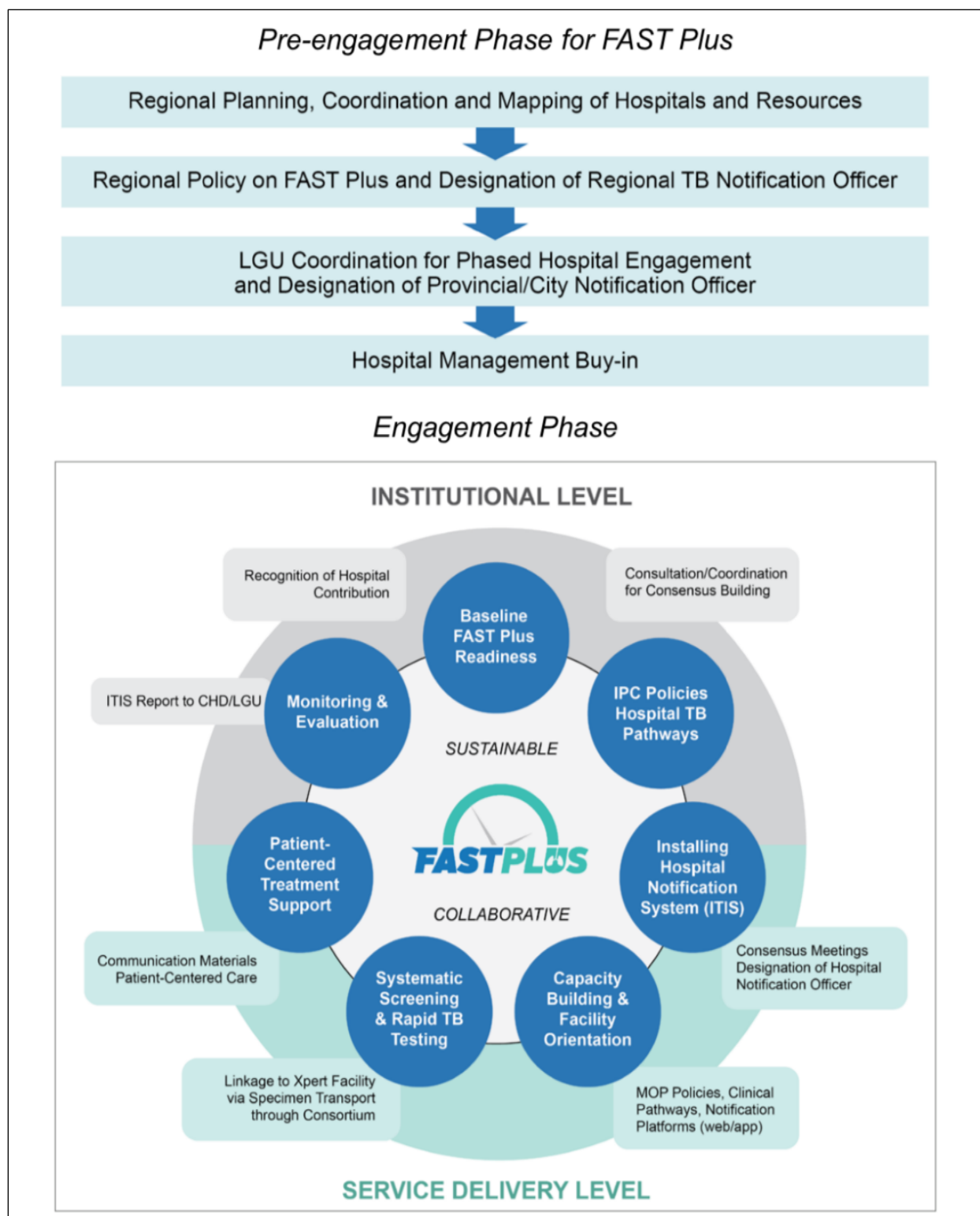


Figure 1. FAST Plus Conceptual and Implementation Framework*

*Adapted from the FAST Plus Briefer, “Harmonized Approach for Engaging Hospitals to End TB in the Context of the COVID-19 Pandemic”

Before the health facilities engaged in FAST Plus, the TB IPs formulated a framework for its implementation, setting three phases of operation: (1) pre-engagement, (2) engagement, and (3) sustainability. The pre-engagement phase involves planning and coordination, policy development, mapping resources for hospital engagement, designating TB notification officers at the regional and provincial/city levels, and promoting institutional buy-in to support FAST Plus in the health facility. The engagement phase involves the hospital's capacity building at the institutional level (to ensure adequate leadership and ownership to continue beyond the engagement phase) and service delivery level (to provide standardized and patient-centered TB care). The sustainability phase entails establishing a hospital-wide TB notification system and staffing, including continuous designation of regional and provincial/city TB notification officers.⁸

TB Platforms and TBIHSS introduced FAST Plus in 301 health facilities in the NCR, Region III, and Region IV-A. The majority (85.3 percent) are public health facilities, and the rest are private. [Table 1](#) provides a breakdown of the types of health facilities that have implemented FAST or ENHANCE, currently integrated as FAST Plus. TB Platforms provides technical assistance to Levels 1 and 2 health facilities, including health centers, and TBIHSS provides technical assistance to Level 3 hospitals.^{9, 10}

Table 1: Total number of health facilities engaged in FAST Plus as of November 19, 2021			
Health facilities implementing FAST Plus	Public	Private	Total
Level 1/Infirmary	41	16	57 (18.9%)
Level 2	6	6	12 (4.0%)
Level 3 (Apex)	32	39	71 (23.6%)
Health Center	161	0	161 (53.5%)
Total	240 (79.7%)	61 (20.3%)	301 (100%)

Source: FAST Engagement Tracker (TB Platforms); FAST Plus L3 Hospital Tracker (TBIHSS)

Some hospitals provide TB-related services, including directly observed treatment, short-course (DOTS), and others refer patients with signs and symptoms that suggest TB (presumptive TB) to other health facilities for diagnostic confirmation and treatment. DOTS-referring facilities can screen presumptive TB cases—with some equipped to do direct sputum smear microscopy (DSSM)—but they have no capacity to initiate TB treatment, register confirmed TB cases, and trace patients who default

⁸ TB Innovations and Health Systems Strengthening, "Harmonizing Approaches for Hospital Engagement to Find, Treat & Notify TB ENHANCE to FAST Plus Approach." 2020.

⁹ TB Innovations and Health Systems Strengthening (TBIHSS), "ENHANCE Fact Sheet," 2021, <https://docs.google.com/document/d/1h6A8LAFTH5prqjHITuSfzGAzCHhe-Vq/edit>.

¹⁰ CLAIHealth, "FAST Plus Monitoring and Evaluation Plan," 2021, https://docs.google.com/document/d/1UQbbFRxYYZ9dRsRIWGP_PMNgbXS0-pHNdwoCuTPNPG4/edit

from treatment. DOTS-providing facilities have all the capabilities of DOTS-referring facilities plus the ability to initiate treatment, do case registration, and conduct treatment default tracing.

2.2. KEY FEATURES OF FAST PLUS

FAST Plus implementation is anchored on the following key features:

- **Systematic screening, testing, and treatment at point of care.** One of the screening strategies employed is to screen patients at all points of entry to the health facility to ensure proper triaging and segregation and limit unnecessary exposure to potentially infectious persons in the waiting areas. Route slips in patient flows can be used to track patients from screening to testing to treatment, including TB notification. FAST Plus facilities use chest radiography as a screening tool for TB and use rapid diagnostic tests such as Xpert MTB/RIF as a primary diagnostic test for TB. Facilities must adopt the updated algorithms and job aids based on the latest NTP Manual of Procedures (MOP), sixth edition, to ensure adherence to the latest TB standards of care.
- **IPC strategies for hospitals.** Pertinent IPC measures while on hospital premises must be conducted from triage to exit, especially during the COVID-19 pandemic. Some actions that can be performed under IPC include investigating close contacts of patients with bacteriologically confirmed TB; cough surveillance (among inpatient watchers, among health care workers [HCWs], and during consultations, especially for persons with diabetes mellitus, HIV, and other immunocompromised conditions); and use of face masks whenever indicated. IPC under FAST Plus also includes TB preventive treatment for eligible patients who are at risk for TB. Other measures include chest X-rays for HCWs at recruitment and annually, identification and separation of presumptive TB cases in the hospital as a result of active surveillance, proper waste management, visible posters on cough etiquette, and use of activity-specific personal protective equipment (PPE) for HCWs and patients, on top of the COVID-19-related minimum public health standards.
- **Hospital notification system for TB.** To have a functional TB notification system, a designated hospital point person for notification activities must be identified. A system for physician registration and notification collection should be properly established in hospitals regardless of physician preferences (paper-based, web-based, or use of mobile app). ITIS is the country's dedicated electronic platform for TB notification, and physicians' ITIS registration and compliance with TB notification should be monitored. Likewise, TB patients who are managed in private clinics inside the hospital premises should be included in the notification process. Establishing a feedback mechanism among hospitals and provincial/city health offices is important, especially for notified cases whose treatment outcomes are not reported.

2.3. COVID-19 AND FAST PLUS

The emergence of COVID-19 as a global health emergency affected the implementation of TB interventions in the Philippines, including FAST Plus. On January 30, 2020, the first confirmed case of COVID-19 was documented in the Philippines. On March 16, 2020, when the government determined there was community transmission of COVID-19, it imposed lockdowns in the NCR and other

provinces. Mobility restrictions brought by the lockdown led to displacement of the TB continuum of care in the affected local government units (LGUs). The DOH NTP reported a 70 percent drop in TB case notification shortly after the lockdown began.¹¹ The World Health Organization also documented the huge effect of the COVID-19 pandemic in the country, citing the Philippines, India, and Indonesia as the three worst-affected countries among the 16 countries contributing to a 93 percent reduction in newly diagnosed TB cases. Between 2019 and 2020, the drop in TB notifications in the Philippines was 12 percent; India recorded a significant drop of 41 percent, followed by Indonesia at 14 percent.¹²

Access to TB care has been influenced by people's perception of the increased risk of acquiring COVID-19 when they leave their houses. In turn, this caused delays or cancellations of appointments for TB consultations, screening, and treatment.¹³ While FAST Plus was focusing on the TB care pathway, the COVID-19 pandemic introduced unforeseen challenges and highlighted the need to adapt. One facilitating factor, however, is that the key features of FAST Plus are similar to some approaches in managing COVID-19 cases in hospitals (e.g., testing, IPC, and case notification through digital platforms—ITIS for TB and COVID-KAYA for reporting COVID-19 cases and contacts).

Despite the restrictions and challenges brought about by the pandemic, FAST Plus is continually implemented in selected hospitals in the three regions. Our initial documentation of the FAST Plus strategy laid the groundwork in understanding the TB–COVID situation and the challenges confronting the health facilities providing TB services, especially in the time of the COVID-19 pandemic.

¹¹ TBIHSS, "ENHANCE Fact Sheet."

¹² World Health Organization, "Tuberculosis Deaths Rise for the First Time in More than a Decade Due to the COVID-19 Pandemic," *World Health Organization*, 2021, <https://www.who.int/news/item/14-10-2021-tuberculosis-deaths-rise-for-the-first-time-in-more-than-a-decade-due-to-the-covid-19-pandemic>.

¹³ TBIHSS, "ENHANCE Fact Sheet."

3. OBJECTIVE AND LEARNING QUESTIONS

This initial GPPI documentation's main objective is to provide an overview of the FAST Plus model and analyze the parameters for documenting the potential of the FAST Plus strategy as a GPPI against its implementation to date in the health facilities that have received technical support from the two TB IPs. Our documentation addresses the following learning questions under five major domains:

1) **Alignment and compliance with international standards and local FAST Plus guidelines:**

- a) How aligned are the local models of FAST Plus with the international standards for FAST (successful FAST models that employ many of the components of FAST Plus)?
- b) What is the level of compliance to the local FAST Plus models/guidelines established among facilities adopting FAST Plus?

2) **Adaptive management and lessons learned:**

- a) What elements work and do not work and in what settings (e.g., facility type, public/private facility, referring/providing facility)?
 - i. What motivates facilities to adopt FAST Plus?
 - ii. What advocacy/promotion mechanisms work and do not work? Why did other facilities drop out of FAST Plus?
 - iii. Behavior change communications (BCC): What BCC initiatives prompt chest X-ray screening and treatment enrollment in hospitals implementing FAST Plus?
- b) What are the key facilitating and hindering factors for the intervention?
- c) What is the impact of the COVID-19 pandemic on various health services and health outputs and outcomes?
- d) What are the adaptive actions that are taken along the way?

3) **Contribution to health outputs and/or outcomes:**

- a) Does FAST Plus lead to better outputs and/or outcomes for screening, testing, treatment, and notifications for TB?
- b) Does FAST Plus lead to improved turnaround time at every phase of the continuum of care?

4) **Replicability:**

- a) What is FAST Plus's potential applicability/replicability in health facilities outside the FAST Plus intervention sites?

- b) What facilitating factors would lead to success—including the potential for sustainability and scale-up—in the Philippine setting?
- 5) **Systems and context:**
 - a) What are structures, systems, and contextual factors related to governance, service delivery, financing, sustainability, and regulation that affect FAST Plus implementation?

4. METHODOLOGY

We consulted the OH TB Cluster in the formulation of this GPPI's scope of work, including the learning questions, the methodology, and the purposive selection of health facilities for the documentation.

The methods we used in this project include: (1) a desk review of relevant literature and available documents and reports from the two HP TB activities; (2) an online survey of the health facilities' compliance to FAST Plus standards and data related to screening, diagnosis, notification, treatment, and turnaround time from 2019 to 2021; and (3) key informant interviews (KIIs) of TB IPs and the 11 health facilities that the IPs recommended. We originally planned to do nonparticipant observations of selected health facilities to validate the KIIs and FAST Plus reports. However, this did not happen because of the surge in COVID-19 cases from the Omicron variant during the data collection period.

4.1. HEALTH FACILITIES INCLUDED IN THE STUDY

We purposively selected 11 health facilities from the NCR, Region III, and Region IV-A, in consultation with the OH, TB Platforms, and TBIHSS. The main considerations for the selection were: (1) IPs identified the facilities as ones that had implemented FAST Plus, (2) IPs endorsed the facilities to be included in the documentation, and (3) the facilities responded to the team saying they are willing to be interviewed and provide the needed information in the surveys. [Table 2](#) shows these health facilities, their pertinent information, and the dates when FAST Plus began. These include four Level 3 hospitals (two public and two private), six Level 2 (five public and one private), and one public health center. Of the 11 facilities, three started in 2019, four in 2020, and another four in 2021. Three hospitals (two Level 2 public, and one Level 3 private) serve as FAST Plus referring facilities, and the rest are providing TB services.

Region	Province or City	Health Facility	Level	Ownership	Facility Type	FAST Plus Start Date
NCR	Taguig	Health Center*	BHS**	Public	Providing TB services	Early 2020
III	Tarlac	Talon General Hospital	L2	Private	Providing	May 2021
IV-A	Laguna	Dr. Jose P. Rizal Memorial District Hospital	L2	Public	Referring	August 2019
III	Bulacan	Ospital ng Guiguinto	L2	Public	Referring	2019
III	Angeles City	Rafael Lazatin Memorial Medical Hospital	L2	Public	Providing	2020
III	Bulacan	Rogaciano M. Mercado Memorial Hospital	L2	Public	Providing	Late 2020
III	Tarlac	Tarlac Provincial Hospital	L2	Public	Providing	2021

Table 2. Health facilities included in the GPPI documentation						
Region	Province or City	Health Facility	Level	Ownership	Facility Type	FAST Plus Start Date
NCR	Makati	Makati Medical Center	L3	Private	Referring	October 2021
NCR	Pasig	The Medical City	L3	Private	Providing	Early 2019
IV-A	Batangas	Batangas Medical Center	L3	Public	Providing	March 2021
NCR	Valenzuela	Valenzuela Medical Center	L3	Public	Providing	July 2020

* For confidentiality reasons, the lone health center in the study sample is not identified by name.

** BHS: barangay health station

4.2. ONLINE SURVEY

We used a self-administered questionnaire for the online survey of health facilities, consisting of two parts. The first part had 11 statements on FAST Plus standards to gauge alignment and compliance with FAST Plus, particularly on TB screening, detection, treatment, and notification. We patterned the questionnaire after the FAST Guide developed by the Nigerian Federal Ministry of Health together with USAID as part of TB Care I.¹⁴ The statements were answerable by yes or no, and we provided a column for remarks.

The second part asked the health facilities for TB data for 2019–2021, particularly: (1) number of clients screened for TB in all service areas and possible entry points, (2) number of patients with presumptive TB who underwent testing (DSSM and Xpert MTB/Rif), (3) number of TB patients enrolled or registered for treatment, (4) number of notified TB cases, and (5) average number of days from release of the results of Xpert MTB/RIF or TB loop-mediated isothermal amplification platform (TB-LAMP) or DSSM to the start of treatment. See [Annex A](#) for a copy of the questionnaire.

We sent the questionnaire to the 11 selected health facilities, but only eight responded. We asked each health facility's FAST Plus focal point to answer the questionnaire and provide contact details, the health facility's name and location, the respondent's designation, and the institution's length of involvement in FAST Plus or TB care.

4.3. KII

We conducted one-hour interviews via Zoom or Google Meet with key informants from the two HP TB IPs and from the 11 health facilities. We sought the key informants' permission to record the interviews, emphasizing privacy and confidentiality of the data gathered. [Annex B](#) shows the KII guide. The key informants from the two TB IPs had 15 questions to answer, and those from the health facilities had 16 questions. These questions were clustered into four sections: (1) compliance to FAST Plus standards, (2) adaptive management and lessons learned, (3) replicability, and (4) systems and context.

¹⁴ Federal Ministry of Health (Nigeria), *FAST ... A Tuberculosis Infection Control Strategy*, 2015, https://www.kncvtbc.org/uploaded/2015/09/fast_strategy1.pdf.

Some questions, like those on replicability, were reserved for the TB IP key informants. We performed content analysis to process and analyze responses to the KIIs.

4.4. LIMITATIONS OF THE DOCUMENTATION

Data collection for this study took place in December 2021 and January 2022. It was difficult to arrange interviews in December because the health facilities' key informants were either busy writing their year-end reports or were on leave for the holidays. The hour-long online interviews were insufficient for probing questions, but, out of respect for the informants' time, we did not extend the sessions. In January 2022, there was a steep surge in COVID-19 cases due to the Omicron variant, so we canceled the planned observations in the health facilities. One of the short-term consultants for the GPPI documentation had to be quarantined because of COVID-19 infections in his household. This report relied mainly on desk reviews, the KIIs' responses, and the online survey. It should be noted that online survey responses were self-reports and could not be validated by observations at the facilities.

5. FINDINGS AND ANALYSIS

The findings of the study are presented by addressing the learning questions for this documentation.

5.1. ALIGNMENT AND COMPLIANCE WITH INTERNATIONAL STANDARDS AND LOCAL FAST PLUS GUIDELINES

- How aligned are the local models of FAST Plus with the international standards for FAST (successful FAST models that employ many of the components of FAST Plus)?
- What is the level of compliance to the local FAST Plus models/guidelines established among facilities adopting FAST Plus?

5.1.1. Alignment of FAST Plus to International Standards and Local FAST Plus Guidelines. The first question was addressed to the TB IPs. The key informants from the two TB IPs said that originally FAST and ENHANCE were implemented separately by the two IPs. FAST is patterned after the internationally implemented FAST by USAID, while ENHANCE is locally developed by TBIHSS. These were later merged into FAST Plus, with emphasis on screening and testing. They also stated that FAST Plus is aligned with the NTP MOP, sixth edition. The TB Platforms informant stated that the inclusion of the pediatric age group TB screening is another FAST Plus element similar to the global FAST model. The experiences and guidelines from Bangladesh, Vietnam, Nigeria, and Georgia guided FAST adaptations for the country.

5.1.2. **Level of Compliance to Local FAST Plus Models among Health Facilities.** [Table 3](#) shows the results of the online survey on the level of compliance among the eight health facilities that responded. One private hospital and one public Level 3 hospital were the most compliant (11 “yes” answers) to the FAST Plus standards. The least compliant was a public Level 2 FAST Plus referring hospital, with six “yes” answers.

Table 3. Compliance to FAST Plus standards, by type of ownership and level									
Facility*	1	2	3	4	5	6	7	8	
Ownership type	Private	Private	Public	Private	Public	Public	Public	Public	No. of “yes” responses
Level of Care	L3	L3	L2	L2	L2	L2	L3	L3	
1. Is cough surveillance being done daily at selected entrance and service areas of your healthcare facility?	yes	yes	yes	yes	yes	yes	yes	yes	8

Table 3. Compliance to FAST Plus standards, by type of ownership and level									
Facility*	1	2	3	4	5	6	7	8	
Ownership type	Private	Private	Public	Private	Public	Public	Public	Public	No. of "yes" responses
Level of Care	L3	L3	L2	L2	L2	L2	L3	L3	
2. Does the patient identified with cough get fast-tracked in screening for other symptoms suggestive of TB according to national guidelines?	yes	yes	yes	yes	yes	yes	yes	yes	8
3a. For presumptive TB patients: Do the health workers instruct the patient to produce and submit sputum samples properly?	yes	yes	yes	yes	yes	yes	yes	yes	8
3b. For presumptive TB patients: Do the health workers educate the patient on respiratory hygiene: cough etiquette and temporary separation?	yes	yes	yes	yes	yes	yes	yes	yes	8
3c. For presumptive TB patients: Are the patients directed to a designated, well-ventilated waiting area to wait for the results OR give appointment for the next day to collect the results?	yes	yes	yes	yes	yes	yes	yes	yes	8
3d. For presumptive TB patients: Are patients provided HIV testing and counseling?	yes	yes	no	yes	no	no	no	yes	4
3e. For presumptive TB patients: Are patients provided COVID-19 testing and counseling?	no	yes	yes	yes	yes	yes	yes	yes	7
4. Are sputum samples for TB tested the same day by a rapid testing method (e.g., direct sputum smear microscopy or Xpert MTB/RIF)?	yes	yes	yes	no	no	yes	yes	yes	6
5. Are TB patients that have a positive sputum test enrolled in DOTS and started on effective TB treatment as soon as they receive the results?	yes	yes	yes	no	no	no	yes	yes	5

Table 3. Compliance to FAST Plus standards, by type of ownership and level									
Facility*	1	2	3	4	5	6	7	8	No. of “yes” respon- ses
Ownership type	Private	Private	Public	Private	Public	Public	Public	Public	
Level of Care	L3	L3	L2	L2	L2	L2	L3	L3	
6. Are data on time to diagnosis and time to treatment collected and monitored regularly?	yes	yes	yes	no	no	yes	yes	yes	6
7. Are TB patients notified using ITIS or ITIS Lite?	yes	yes	yes	yes	no	yes	yes	yes	7
“Yes” answers per facility	10	11	10	8	6	9	10	11	

*For confidentiality reasons, health facilities are not identified by name. The designated number for each hospital is in no particular order.

All eight hospitals agreed with the first five statements: daily cough surveillance; fast-tracking of patients with cough; HCW instructions to patients on proper expectoration and submission of sputum samples; HCW education of presumptive TB patients on respiratory hygiene; directing presumptive TB patients to a designated, well-ventilated area or setting an appointment the following day for laboratory results.

However, four health facilities (three public Level 2 hospitals and one public Level 3 hospital) answered “no” to the statement on presumptive TB patients being provided with HIV testing and counseling. Three Level 2 facilities (one private and two public hospitals) responded “no” to the statement on enrollment of TB patients in DOTS and starting patients on effective TB treatment right after obtaining the results.

The designation of personnel who are responsible for implementing FAST Plus is an important aspect of the health facilities’ compliance to FAST Plus. [Table 4](#) shows that most of the health facilities have staff assigned for FAST Plus. Some of these include entire units like the Pulmonology Departments of two Level 3 private hospitals, or a core team of health providers. The public health center included in this documentation has a diagnostic committee responsible for overseeing FAST Plus in its facility.

Table 4. FAST Plus personnel in health facilities	
Health facility,* type and level	FAST Plus personnel
Level 3 facility: public	
7	No information
8	Core staff: Department of Family and Community Medicine (DFCM), nurse supervisor
10	NTP physician (head resident), satellite treatment center physician

Table 4. FAST Plus personnel in health facilities	
Health facility,* type and level	FAST Plus personnel
Level 3 facility, private	
1	Pulmonology department as the lead Infectious diseases section, pediatrics department (facility reports that all departments are involved)
2	Program manager for DOTS, a nurse, newly hired midwife, and the pulmonology department TB Council: Section of pulmonology, infectious diseases section, hospital infection control and epidemiology center, DOTS (all under the Office of the Chief Medical Officer), department chairs as TB champions
Level 2 facility, public	
3	Emergency room nurses, triage nurses, other doctors/whole hospital due to referrals, nurses hired by the Philippine Business for Social Progress for drug-resistant TB patients, one nursing attendant
5	Officer-in-charge (physician), two trained residents, two nurses, two trained medical technologists
6	One satellite treatment center physician, one physician from the outpatient department
9	Resident on duty (all departments), infection control nurse, physician in charge of TB DOTS, pharmacists, front desk staff, laboratory and radiology staff
Level 2 facility, private	
4	One physician, but all staff are aware of FAST Plus, especially in the emergency room
Health center	
11	Diagnostic committee comprised of a pulmonologist, TB coordinator, a nurse coordinator, a pathologist, and five other members

*For confidentiality reasons, health facilities are not identified by name. The designated number for each hospital is in no particular order.

Most of the health facilities have developed FAST Plus- or TB-related policies or were in the process of crafting them during our data collection period (see [Table 5](#)). For example, the medical director in a private Level 3 hospital released two memos on mandatory notification were released but a FAST PLUS hospital policy is still being developed. At Rogaciano M. Mercado Memorial Hospital (RMMMHH), there is no face-to-face provision of services at the OPD. The hospital revised the policy specifying that the COVID-19 triage supports TB screening for symptomatic cases. At Valenzuela Medical Center, there is a unified policy for both TB and COVID-19 screening. At the Rafael Lazatin Memorial Medical Hospital, however, no new FAST Plus-related policies were formulated because these were “overtaken by COVID-19 policies from DOH region,” implying that the pandemic receives more priority in the facility. Other facilities like OG and UHC have integrated the FAST Plus policies into other health programs.

Table 5. Hospital policies related to FAST Plus	
Health facility,* type and level (L)	FAST Plus policies
Level 3 facility: public	
7	Added a new unified policy (“new normal”); ISO accredited; COVID-FAST Plus screening form (hospital order).
8	TB policy (latest ISO); memo from the medical director; transitioned to internal forms and included FAST Plus flow from screening to treatment; incorporated NTP MOP sixth edition and NTP Adaptive Plan (NAP)
10	Hospital Order specific to TB management.
Level 3 facility, private	
1	New policies or guidelines (memo on mandatory notification through Google form)
2	The medical director released two memos on mandatory notification but the hospital policy on FAST Plus is still being developed. A TB algorithm was issued in 2018 as part of the of the policies on behavior change. The hospital staff started using this prior to the integration of FAST Plus.
Level 2 facility, public	
3	No face-to-face in the OPD. Hospital revised the policy in the sense that the COVID-19 triage supports TB screening for symptomatic cases. No other revision in the facility because the physical setup is still accessible to patients. The NTPMOP is being followed for TB care.
5	10 related policies involving IPC from the provincial health office.
6	No new policies on FAST Plus because COVID-19 policies from DOH regional office are given more attention
9	No answer
Level 2, private	
4	There are new policies on FAST Plus but previous policies on TB were added. The new policies include a checklist and survey tools, FAST Plus algorithm, and the use of Xpert MTB/RIF.
Health center	
11	FAST Plus policy is incorporated in its health programs.

*For confidentiality reasons, health facilities are not identified by name. The designated number for each hospital is in no particular order.

5.2. ADAPTIVE MANAGEMENT AND LESSONS LEARNED

- What motivates facilities to adopt FAST Plus?
- What advocacy/promotion mechanisms work and do not work?
- Why did other facilities drop out of FAST Plus?
- What BCC initiatives prompt chest X-ray screening and treatment enrollment in hospitals implementing FAST Plus?
- What are the key facilitating and hindering factors for the intervention?
- What is the impact of the COVID-19 pandemic on various health services and health outputs and outcomes?
- What are the adaptive actions that are taken along the way?

5.2.1. **What motivated facilities to adopt FAST Plus?** Informants from all the hospitals expressed said that they adopted FAST Plus to improve their knowledge about TB care so that they are better able to diagnose and identify more TB cases. The public health center is adopting FAST Plus because it is already providing free services for TB patients. Having a good collaborative relation with the LGU/mayor motivated public Level 2 hospitals to adopt FAST Plus. Public Level 3 hospitals were motivated by their supportive administrations, core teams of TB health workers, good relationships with external partners, and high TB patient enrollment. Private Level 3 hospitals cited the following: supportive administrations; belief that FAST Plus is a DOH requirement; free TB drugs for their patients.

On the other hand, key informants from the two TB IPs believed that the main motivating factor for the health facilities to adopt FAST Plus the latter's desire to align their TB programs with the NTP MOP, sixth edition. Additionally, TB Platforms mentioned that the health facilities wanted to gain more knowledge about the TB screening protocol, with TBIHSS opined that health facilities adopted FAST Plus to receive technical assistance from the IPs.

5.2.2. What advocacy/promotion mechanisms work and do not work?

5.2.2.1. *Effective advocacy/promotion mechanisms of health facilities, according to TB IPs.* When asked about the advocacy/promotion mechanisms in various FAST Plus facilities, the key informants from the two TB IPs focused only on what worked for the health facilities. They stated that regular communication, advocacy, and promotion of the FAST Plus elements within the hospital management and staff are effective. TB Platforms stated that holding advocacy meetings and training activities for HCWs and hospital staff are good strategies. TBIHSS cited mechanisms targeting both the HCWs and patients, such as posters and audiovisual messages in outpatient departments.

5.2.2.2. *Effective FAST Plus advocacy/promotion mechanisms, according to health facilities.* The health facilities interviewed used different advocacy/promotion mechanisms for FAST Plus. Public and private Level 3 hospitals use posters as an advocacy tool. Counseling is practiced at public and private Level 2 hospitals. One-on-one education/discussion with patients at done at the public health center and in Level 3 public hospitals.

Private Level 2 and 3 hospitals use social media posts to advocate for FAST Plus services in their facilities. Public Level 2 and 3 hospitals also mentioned virtual chatrooms and zoom orientation as their avenues for advocacy/promotion.

More specific mechanisms are practiced at different levels and types of health facilities. The public health center advertises free chest X-ray and Xpert MTB/Rif services and highlights the advantages of receiving TB treatment. The key informant from the public health center KI stated, “*Masigasig ang TB Task Force na mag-house-to-house para magpaliwanag tungkol sa TB at kumuha ng mga contact numbers.*” [The TB Task Force enthusiastically go from house to house to explain about TB and to get contact numbers.]

Public Level 2 hospitals conduct home visits, provide free chest X-ray vouchers, and integrated diabetes mellitus – TB screening and management. Public Level 3 hospitals hold consultative meetings with resident doctors and hold health talks within their facilities. A private Level 3 hospital mentioned their “lay fora” for patients and clients in March 2021 and August 2021 via Facebook.

[Table 6](#) shows the variations in advocacy and promotion mechanisms used by types and levels of health facilities. The health facilities, however, did not identify ineffective mechanisms.

	Health Center	Level 2 Hospital	Level 3 Hospital
Public health facility	<ul style="list-style-type: none"> • Advertising free services (chest X-ray, Xpert) • Highlighting the advantages of consultations • One-on-one patient education 	<ul style="list-style-type: none"> • Use of virtual chatrooms • Home visits • Free chest X-ray vouchers • Integrated diabetes mellitus – TB screening and management • Counseling 	<ul style="list-style-type: none"> • Posters • Zoom orientation • Consultative meeting with resident physicians • Health talks • One-on-one discussions with patients
Private health facility	N/A	<ul style="list-style-type: none"> • Social media posts • Counseling treatment 	<ul style="list-style-type: none"> • Social media posts • Lay fora • Posters

5.2.3. Why did other facilities drop out of FAST Plus?

We raised this learning question only with the key informants from the TB IPs. The TB Platforms cited the following reasons for dropping out of FAST Plus: lukewarm reception from facilities, small human resources pool who can competently perform TB screening, non-compliance with standards of care, and

the increased number of resignations during the early days of the COVID-19 pandemic. There was also a perception among these facilities that adopting FAST Plus would entail more work for the staff. Some physicians, on the other hand, saw the need to undergo retraining about the latest TB practice guidelines (NTP MOP, sixth edition) as a deterrent. A private Level 1 facility in the NCR reportedly dropped out because it was unable to implement FAST Plus properly.

TBIHSS stated that there are no dropouts to date among their partner hospitals, which are mostly apex or Level 3 hospitals. However, some of these health facilities have encountered some delays in implementation for varied reasons, e.g., the issuance of a DOH memorandum regarding the implementation of the NTP Adaptive Plan in the context of COVID-19.

5.2.4. What BCC initiatives prompt chest X-ray screening and treatment enrollment in hospitals implementing FAST Plus?

We directed this learning question only to the key informants of the health facilities. They found counseling and health education to be useful in convincing people to undergo chest X-ray screening and treatment. As a result, a key informant from a public Level 2 hospital said, "*Hindi na gaanong nahihiya ang mga TB patient namin kasi alam na nila ang gagawin nila.*" [Our TB patients are no longer embarrassed because they already know what to do.] An interviewee from a private Level 3 hospital noted that there is no resistance if the patient is properly informed about chest X-ray screening and treatment.

5.2.5. What are the key facilitating and hindering factors for the intervention?

Health facilities regard support from the LGU and hospital as facilitating factors for adapting FAST Plus. A private Level 2 hospital recognized the contribution of the LGU in supporting barangay health workers who actively promote chest X-ray screening and Xpert testing in its catchment area. A key informant from a public Level 3 hospital acknowledged that the support, good relations, and work ethic of the health personnel facilitated successful implementation of FAST Plus in their hospital. A public Level 2 hospital cited the availability of Xpert and DSSM as well as a pool of knowledgeable staff as significant facilitating factors.

Some health facilities mentioned hindering factors in the successful implementation of FAST Plus. A public Level 3 hospital cited the following inhibiting factors: absence of a TB committee, doctors' poor compliance with the standard of care, and poor data management and referral systems. In three Level 2 hospitals, patients who provide false personal information prevent the hospitals from following-up with patients with TB. Other hindering factors mentioned were: weak internet connection, the long treatment of TB patients, and insufficient financial support for patients.

5.2.6. What is the impact of the COVID-19 pandemic on various health services and health outputs and outcomes?

We directed this learning question to the key informants from the health facilities, who consistently said that at the start of the pandemic, their health facilities had to shift their resources to the COVID-19

response. Moreover, TB patients were hesitant or did not visit their health facilities due to their fear of getting infected with the virus.

According to a key informant from a public Level 2 hospital, *“Takot pa rin pong pumunta sa ospital yung iba naming pasyente. Kaya yung mga STRiders na namin ang kumukuha ng mga sputum specimen ng mga pasyente na ayaw pumunta sa amin.”* [Our other patients are still afraid to come to the hospital, so our STRiders pick up the specimen from the patients who do not want to come to us.]

Another key informant from a private Level 2 hospital shared their health facility’s difficulty at the start of the pandemic:

“Ang isang problema namin noong unang dumating dito ang COVID ay minsan hindi namin mapa-GeneXpert yung pasyenteng COVID-positive para malaman kung may TB rin.” [One problem when COVID-19 first occurred here was that sometimes we could not use GeneXpert for a patient who was COVID-positive to determine if this patient also has TB.]

This partly explains the reduction in the number of TB screenings and notifications at their health facilities.

At a private Level 3 hospital, for example, the nurses who were knowledgeable about FAST Plus were reassigned to COVID-19 services. There was also limited interaction with admitted TB patients who were placed on the floor designated for COVID-19 patients. In a public Level 2 hospital, the facility was overwhelmed by the influx of COVID-19 patients. This, however, led the hospital to develop a system of screening TB alongside COVID-19 cases.

The key informant from this hospital said, *“Naging mas mabusisi kami sa pag-screen para sa COVID at TB, lalo sa mga pasyenteng may sintomas na parang COVID-19 o TB. [We became more meticulous in screening for COVID and TB, especially for patients who have COVID-19 or TB symptoms.]*

5.2.7. What are the adaptive actions that are taken along the way?

TB Platforms temporarily suspended its technical assistance for FAST Plus implementation in Level I health facilities because of the pandemic. The Level 3 health facilities assisted by TBIHSS tried to sustain their operations by developing or adopting adaptive policies (such as NAP) in relation to the COVID-19 pandemic and by providing online capacity building activities for their TB staff.

Public Level 2 hospitals required clients to have an RT-PCR test for SARS CoV-2 prior a TB diagnostic test on sputum. Their health workers also reportedly delivered the anti-TB medicines to the homes of patients with TB. A key informant from a public Level 3 hospital said, *“Kapag hindi makakapunta sa ospital ang TB patient dito, kami ang nagdadala ng serbisyo sa community nila.”* [If the patient cannot come to the hospital, we bring the services to their community.] Similarly, a public Level 2 hospital interviewee stated, *“Ang mga tao namin ang magdadala ng gamot sa kanto-kanto nung panahon ng pandemic.”* [Our staff brought the medicine to the neighborhood during the pandemic.]

A private Level 2 hospital made adjustments in counseling their TB clients by requiring their clients to observe public health standards for COVID-19. For Level 3 hospitals, whether public or private, the most common adaptive actions during the pandemic were: a) simultaneous TB and COVID-19 screening; b) separation of patients based on their COVID-19 status; and c) the use of online services such as teleconsultations. Telemedicine is a viable option for Level 3 hospitals because they have the funds to start and sustain this platform and a sufficient pool of human resources to manage a telemedicine system. Additionally, through delivery services of Grab and Lalamove, a private Level 3 hospital sent medicines to their patients who received teleconsultation.

The health facilities also administer questionnaires to patients about COVID-19 and TB in all entry points, exit points, and rooms designated for TB cases. Public Level 3 hospitals merged the TB and COVID-19 screening forms. Mandatory use of appropriate PPE during TB screening was also practiced. [Table 7](#) shows differences in adaptive actions taken by Level 2 and Level 3 hospitals.

Table 7. Adaptive actions of health facilities during the COVID-19 pandemic*		
	Level 2 Hospitals	Level 3 Hospitals
Public	<ul style="list-style-type: none"> • RT-PCR first before sputum • Anti-TB medicines are brought to the patient's house 	<ul style="list-style-type: none"> • Merged COVID-19 and TB screening form • Mandatory use of appropriate PPE during TB screening • Simultaneous TB and COVID-19 screening • Separation of patients based on COVID-19 status • Adoption of NTP Adaptive Plan • Telemedicine
Private	<ul style="list-style-type: none"> • Adjustment to counseling (minimum public health standards) 	<ul style="list-style-type: none"> • Telemedicine • Courier service (e.g., Lalamove, Grab) • Simultaneous TB and COVID-19 screening • Separation of patients based on COVID-19 status

* There were no adaptive actions cited by the public health center interviewed.

5.3. CONTRIBUTIONS TO HEALTH OUTPUTS AND/ OR OUTCOMES

- Does FAST Plus lead to better outputs and/or outcomes for screening, testing, treatment, and notifications for TB?
- Does FAST Plus lead to improved turnaround time at every phase of the continuum of care?

5.3.1. Does FAST Plus lead to better outputs and/or outcomes for screening, testing, treatment, and notifications for TB?

This section presents information provided by the eight health facilities that participated in the online survey regarding their 2019–2021 performance on the following: a) clients screened for TB in all service areas or possible entry points; b) presumptive TB patients who underwent DSSM and/or Xpert testing; c) TB patients enrolled or registered for treatment; d) number of notified TB cases, and 3) average number of days from release of Xpert/TB-LAMP/DSSM result to start of treatment.

5.3.1.1. *Clients screened for TB in all service areas or possible entry points.* [Table 8](#) shows that from 2019 to 2020, six of the eight health facilities experienced a significant drop in the number of clients who were screened for TB in all service areas or possible entry points. One hospital has no data for 2019 and 2020 because it only started FAST Plus in 2021. Another hospital did not give data for 2019 but it shows that its TB clients decreased from 2020 to 2021. Although the data for 2021 is incomplete, the number of TB clients for this year further went down in four hospitals. Only one hospital's TB clients increased from 2020 to 2021.

Table 8. Number of clients screened for TB in all service areas or possible entry points, 2019–2020					
Health Facility*	Level	Ownership	Year		
			2019	2020	2021**
1	L3	Private	Data not available	Data not available	36,106
2	L3	Private	Data not available	47,603	41,541
3	L2	Public	121,932	51,585	36,496
4	L2	Private	63,046	38,243	22,996
5	L2	Public	168	93	130
6	L2	Public	478	152	102
7	L3	Public	3,487	986	2,957
8	L3	Public	4,314	1,538	1,164

* For confidentiality reasons, health facilities are not identified by name. The designated number for each hospital is in no particular order.

** For 2021, data are only for Quarters 1 and 2.

5.3.1.2. *Presumptive TB patients who underwent testing (DSSM and Xpert).* [Table 9](#) shows a similar downward trend for 2019–2020 in the number of TB presumptive clients who underwent testing, particularly in one public Level 3 hospital, one private Level 3 hospital, one public Level 2 hospital, and one private Level 2 hospital. However, one private Level 3 hospital and one public Level 2 hospital saw an increase in the first two quarters of 2021. No information was obtained from three hospitals in 2019 to make a comparison about their performance in the succeeding year.

Table 9. Number of presumptive TB patients who underwent TB testing (DSSM and Xpert), 2019–2020					
Health Facility*	Level	Ownership	Year		
			2019	2020	2021 **
1	L3	Private	Data not available	Data not available	1,489
2	L3	Private	8,326	3,777	4,046
3	L2	Public	1,584	1,210	1,235
4	L2	Private	99	72	49
5	L2	Public	127	130	87
6	L2	Public	No answer	152	102
7	L3	Public	1,345	634	359
8	L3	Public	File not available	1,023	1,023

*For confidentiality reasons, health facilities are not identified by name. The designated number for each hospital is in no particular order.

** For 2021, data are only for Quarters 1 and 2.

5.3.1.3. *TB patients enrolled or registered for treatment.* [Table 10](#) shows that for six hospitals, the number of TB patients enrolled for treatment in 2019 ranged from 15 (in a public Level 2 hospital) to 695 (in a private Level 3 hospital). In 2020, four hospitals (one private Level 3 hospital, two public Level 3 hospitals, and one public Level 2 hospital) reported a decrease in the number of patients enrolled or registered, but two public Level 2 hospitals saw an increase. From 2020 to 2021, seven hospitals reported that the number of registered TB patients increased.

Table 10. Number of TB patients enrolled in or registered for treatment, 2019–2020					
Health Facility*	Level	Ownership	Year		
			2019	2020	2021**
1	L3	Private	Data not available	Data not available	111
2	L3	Private	695	332	293
3	L2	Public	249	262	311
4	L2	Private	Data not available	No answer	No answer
5	L2	Public	15	55	31
6	L2	Public	45	31	35
7	L3	Public	38	21	25
8	L3	Public	206	159	164

* For confidentiality reasons, health facilities are not identified by name. The designated number for each hospital is in no particular order.

** For 2021, data are only for Quarters 1 and 2.

5.3.1.4. *Number of TB notified cases.* The information in [Table 11](#) was provided by seven hospitals and shows a lower number of TB notifications relative to those who were registered or enrolled for treatment (e.g., for 2019, range of 7 to 557). Except for one public Level 3 hospital, the number of TB case notifications decreased from 2020 to 2021. The decline in the number of notified cases continued for most health facilities in 2021.

Table 11. Number of TB case notifications, 2019–2021					
Health Facility*	Level	Ownership	Year		
			2019	2020	2021**
1	L3	Private	7	4	12
2	L3	Private	136	18	3
3	L2	Public	249	262	311
4	L2	Private	557	312	171
5	L2	Public	All	All	All
6	L2	Public	478	152	102
7	L3	Public	No answer	No answer	No answer
8	L3	Public	253	325	341

5.3.2. Does FAST Plus lead to improved turnaround time at every phase of the continuum of care?

5.3.2.1. Average number of days from release of Xpert/TB-LAMP/DSSM result to start of treatment. Only three hospitals gave information on turnaround time for 2019. For the five hospitals that provided information for 2020 and 2021, [Table 12](#) shows no change in the average turnaround time from release of results of Xpert/TB-LAMP/DSSM to treatment in these health facilities and that there is still a considerable lag time from bacteriologic confirmation to treatment (range: 2–7 days) (see [Table 12](#)).

Table 12. Average number of days from release of Xpert/TBLAMP/DSSM result to start of treatment, 2019–2020					
Health Facility*	Level	Ownership	Year		
			2019	2020	2021**
1	L3	Private	Data not available	Data not available	2 days
2	L3	Private	Data not available	7 days	7days
3	L2	Public	2.3 days	2.3 days	2.3 days
4	L2	Private	Data not available	No answer	No answer
5	L2	Public	Variable	Variable	Variable
6	L2	Public	No answer	2-3 days	2-3 days
7	L3	Public	3 days	3 days	3 days
8	L3	Public	3-5 days	3-5 days	3-5 days

*For confidentiality reasons, health facilities are not identified by name. The designated number for each hospital is in no particular order.

**For 2021, data are only for Quarters 1 and 2.

5.4. REPLICABILITY

- What is FAST Plus’s potential applicability/replicability to health facilities outside the FAST Plus intervention sites?
- What facilitating factors would lead to success—including the potential for sustainability and scale-up—in the Philippine setting?

5.4.1. What is FAST Plus’s potential applicability/replicability to health facilities outside the FAST Plus intervention sites?

We raised this learning question with the key informants from the HP TB IPs. TB Platforms said that FAST Plus is potentially replicable to sites outside of the current FAST Plus facilities but this can only take place if the DOH NTP promotes this intervention directly in these areas. This would require an NTP-supportive policy to guide these facilities on how to start and sustain FAST Plus. TBIHSS stated that the establishment of referral networks that are linked with the country’s Universal Health Care (UHC) program is important to boost FAST Plus replicability.

To be replicable, good evidence on the effectiveness of FAST Plus should be provided. However, the performance data on screening, testing, notification and treatment for 2019–2021 from the participating health facilities did not clearly demonstrate effectiveness, largely because of the profound effects of the COVID-19 pandemic on the delivery of TB and other health services in the country. Further documentation will be required through the life of project of the two TB IPs and, indeed, beyond project life as the post-COVID era unfolds.

5.4.2. What facilitating factors would lead to success—including the potential for sustainability and scale up—in the Philippine setting?

TB Platforms considers the following as important factors for success: equipping all referring facilities with an Xpert machine (and cartridges), establishing an efficient sputum transport mechanism, and the optimizing the use of the ITIS for timely referrals. TBIHSS added the importance of licensing facilities, investing in TB care providers, and identifying TB champions as effective means to sustain FAST Plus and reach the goals of a TB-free Philippines.

5.5. SYSTEMS AND CONTEXT

What structures, systems, and contextual factors related to governance, service delivery, financing, sustainability, and regulation affect FAST Plus implementation?

The HP TB IPs and the health facilities highlighted the importance of a supportive hospital administration and the LGU in the successful implementation of FAST Plus. The key informant from a private Level 3 hospital shared, “*Supportive ang admin namin sa FAST Plus. Nabigyan din [kami] ng award for best hospital TB DOTS program for two consecutive years.*” [Our administration is supportive of FAST Plus. We were also given an award for best hospital TB DOTS program for two consecutive years.]

For effective FAST Plus implementation, the TB IPs also noted the importance of having a clear government policy for TB. TBIHSS added that other interventions like telecontact investigation, TB preventive treatment, financing especially in the context of UHC, and observance of data privacy are essential for the success of FAST Plus.

For training hospitals, involving medical interns and fellows in FAST Plus implementation can also improve efficiency. Other specific comments included budgetary support, PhilHealth reimbursements, and better coordination among hospitals, rural health units, and the provincial government.

6. CONCLUSION

FAST Plus is a relatively new TB strategy that combines the best of the FAST and ENHANCE strategies implemented by TB Platforms and TBIHSS. Its launch in 2018 and implementation from 2019 onward showed promise as an effective approach to screening, treatment, notification, and prevention of TB and ultimately finding and treating the 2.5 million missing patients with TB. FAST Plus has been implemented in 301 health facilities in the “big three” high-TB-burden regions of the NCR, Region III, and Region IV-A.

The evidence collected virtually by this landscape analysis of 111 health facilities, which provide different levels of health care in the public and private sectors, suggests that the FAST Plus strategy meets five of the seven GPPI criteria: commitment, alignment, integration, inclusiveness, and resources. FAST Plus is aligned with the country’s NTP MOP sixth edition and the NTP Adaptive Plan. The FAST component of FAST Plus is also aligned with the global FAST strategy, a practice implemented in other countries. The online survey indicates that most of the health facilities, including hospital administration, are committed to the FAST Plus strategy and are compliant with the FAST Plus standards of care. FAST Plus is integrated into the workflows of the providing and referring health facilities.

FAST Plus is also inclusive, as manifested by the health facilities’ “screen-all” policies, even during the surging COVID-19 pandemic. Some facilities reported they extend screening and treatment in their communities, either by using mobile equipment or through STRiders who can pick up specimens from patients and deliver them to testing facilities. Patients seen at tertiary hospitals are also referred back to an LGU TB DOTS facility to ensure the services are located near the patients. The health facilities reported they have the needed FAST Plus resources, particularly anti-TB drugs, equipment, and health workers. LGUs reportedly augment some of the resources they need to operate their TB units. The TB IPs also provide technical assistance to the health facilities to build staff capacity and sustain services.

FAST Plus has the potential to be replicable, but the performance data, which showed promise pre-COVID, do not provide sufficient evidence for effectiveness. Most of the selected health facilities for this initial documentation had started implementing FAST Plus just before or during the first two years of the COVID-19 pandemic. Thus, it is not surprising that the performance data we gathered from the health facilities for screening, testing, treatment, and case notifications decreased considerably in 2020–2021 compared to 2019. This decrease is largely attributed to the COVID-19 pandemic’s effects on the health system and health services in general, but even more so on the TB burden, which is very similar to COVID-19 in terms of symptoms, stigma, fear, discrimination, and even diagnostic testing through Xpert. Although the DOH NTP, OH, TB IPs, and health facilities introduced innovations and adaptations to facilitate FAST Plus implementation, there were systemwide hindering factors that derailed gains in the TB program that had been achieved in 2018–2019.

Nevertheless, based on the five GPPI criteria that FAST Plus met, our landscape analysis indicates that FAST Plus is a promising intervention. Evidence of effectiveness and replicability will need to be demonstrated in the remaining years of TB Platforms and TBIHSS. The two TB IPs that have been providing technical assistance to many health facilities in the “the big three” regions say FAST Plus has

the potential to be replicable and sustainable, but this largely depends on direct promotion and championship by the DOH NTP, LGUs, and hospital administrations as well as the establishment of referral networks and improved health financing as part of the UHC Law.

7. RECOMMENDATIONS

This initial documentation and landscape analysis lays the groundwork for more robust GPPI documentation of FAST Plus. It should segue into joint documentation by TB Platforms and TBIHSS beyond the current analysis by CLAIHealth. Both IPs have the reach and presence to obtain more complete data on effectiveness from all health facilities implementing FAST Plus and on the processes that facilitate or hinder successful implementation. We recommend a common GPPI documentation protocol, regular exchange and consolidation of information and data through the OH TB Cluster meetings, and joint pause-and-reflect sessions.

We also recommend related research studies to enhance and accelerate FAST Plus implementation throughout the country, for example:

- Implementation research comparing FAST Plus implementation at different levels and types of health facilities
- Case studies of the most and least compliant health facilities with respect to FAST Plus
- Assessment of the technical assistance for FAST Plus from the HP TB IPs
- Evaluation of FAST Plus by comparing FAST Plus and non-FAST Plus health facilities
- Study of the contributions to FAST Plus from other stakeholders (e.g., DOH NTP, LGU officials, PhilHealth, professional and other civil society organizations, and TB patients)

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ANNEX A: SURVEY QUESTIONS

Survey Questions (Adopted from FAST Guidelines of the Nigerian Federal Ministry of Health)¹⁵

Part I is intended for TB point persons of hospitals/health facilities (can be validated c/o field officers or coordinators as well and completed per facility) to gauge compliance to FAST Plus Standards

Part II is intended for TB point persons of hospitals/health facilities (can be validated c/o field officers or coordinators as well and completed per facility) to gather quantitative information on outcomes related to FAST Plus components.

Background Information

Name:

Contact Number and/or email address:

Organization and Designation:

Length of Involvement in FAST Plus or TB care in your organization:

Name of Facility: _____

Address of Facility: _____

Part I. Kindly check the corresponding box per item, answering with either a YES or a NO.

Questions	YES	NO
1. Is cough surveillance being done daily at selected entrance and service areas of your healthcare facility?		
2. Does the patient identified with cough gets fast-tracked in screening for other symptoms suggestive of TB according to national guidelines?		
3a. For presumptive TB patients: Do the health workers instruct the patient to produce and submit sputum samples properly?		
3b. For presumptive TB patients: Do the health workers educate the patient on respiratory hygiene: cough etiquette and temporary separation?		
3c. For presumptive TB patients: Are the patients directed to a designated, well-ventilated waiting area to wait for the results OR give appointment for the next day to collect the results?		
3d. For presumptive TB patients: Are patients provided HIV testing and counseling?		
3d. For presumptive TB patients: Are patients provided COVID-19 testing and counseling?		
4. Are sputum samples for TB tested the same day by a rapid testing method (e.g., direct sputum smear microscopy or Xpert MTB/RIF)?		

¹⁵ Federal Ministry of Health Nigeria & USAID TB Care I. FAST... A Tuberculosis Infection Control Strategy. September 2015. Available from https://www.kncvtbc.org/uploaded/2015/09/fast_strategy1.pdf

5. Are TB patients that has a positive sputum test enrolled in DOTS and started on effective TB treatment as soon as they receive the results?		
6. Are data on time-to-diagnosis and time-to-treatment collected and monitored regularly? <i>* Time to Diagnosis: The number of days from the date of patient presentation on which sputum was collected (column: Date of collection) to the date the lab result was received (column: Date result released) as recorded in the clinic TB suspect register</i> <i>* Time to Treatment: The number of days from the date on which the lab result was received (column: Date registered) to the date treatment was initiated (column: Date treatment started) as recorded in the clinic TB suspect register. For drug-resistant TB, the date the lab result was received shall be recorded in the Comments column and the date of treatment start shall be recorded in the Treatment facility referred to column</i>		
7. Are TB patients being notified using ITIS or ITIS Lite?		

Part II. Kindly fill in with the relevant figures/values in the corresponding space.

Indicator	2019	2020	2021 (January to September)
1. Number of clients screened for TB in different service areas / all possible entry points			
2. Number of presumptive TB patients identified			
3. Number of presumptive TB patients who underwent testing (e.g., DSSM, Xpert MTB/RIF)			
4. Number of diagnosed TB patients (in your facility)			
5. Number of TB patients enrolled or registered for treatment			
6. Number of cured/completed enrolled TB cases			
7. Average number of days from release of Xpert/TBLAMP/DSSM results to the day treatment is started.			
8. Number of policies related to infection prevention and control (IPC)			
9. Number of diagnosed index cases with 100% household contacts screened for TB			
10. Number of diagnosed index cases			
11. Number of health workers (e.g., doctors, nurses, medical technologists) in the facility that have been screened as part of the facility infection control program			

12. Number of registered physicians in mandatory notification			
13. Number of physicians notifying TB cases			
14. Number of notified TB cases			
15. Number of policies in the facility related to mandatory notification			

**Please use space below to provide disaggregation per month, especially for numbers 1, 2, 3, 4, 5, 12, 13 and 14.*

ANNEX B: KEY INFORMANT INTERVIEW GUIDE

Introduction

Thank you for the opportunity to conduct this interview with you. We are consultants of USAID's CLAIHealth Project involved in the Good Practices and Promising Interventions (GPPI) initiative on FAST Plus. We assure you that all the information that you will provide will be used exclusively for our research and analysis. We will also be recording the session for purposes of comprehensively capturing the proceedings of this interview. Responses will appear anonymously in the reports/deliverables. This is not a test, and there are no right or wrong answers. Please feel free and take your time in expressing your opinions and discussing your answers. You can opt out of this interview at any time.

Background Information

Name:

Sex:

Email address:

Organization and Designation:

Length of Involvement in FAST Plus or TB care in your organization

Compliance to FAST Standards

For TBIHSS and TB Platforms	For hospitals/health care facilities
<ol style="list-style-type: none">1. What elements of FAST Plus which are adopted locally are similar to the global or international standard of FAST?2. Generally, how compliant are the engaged hospitals you handle to the FAST Plus guidelines given to them?3. In what ways are they compliant?4. In what way is compliance challenging for the engaged hospitals?	<ol style="list-style-type: none">1. What do you know about FAST Plus?2. For how long has FAST Plus been implemented in your facility?3. What activities are being done in your facility for presumptive TB patients? For those with confirmed TB?4. Who are involved in the activities mentioned in number 3?5. Are there policies or guidelines being followed for these?6. Among the activities mentioned in number 3, which among these happened in your facility after FAST Plus was introduced?

Adaptive Management and Lessons Learned

For TBIHSS and TB Platforms	For hospitals/health care facilities
<ol style="list-style-type: none">5. What motivated facilities to adopt FAST Plus?6. What advocacy/promotion mechanisms worked, and what did not work?	<ol style="list-style-type: none">7. Which among these components/activities mentioned worked in terms of screening, testing, treatment, and notification? Why?

<p>7. Why did other facilities drop out of FAST Plus?</p> <p>8. What behavior change communication initiatives prompted chest X-ray screening and treatment enrollment in hospitals implementing FAST Plus?</p> <p>9. What are the key facilitating and hindering factors for the intervention?</p> <p>10. What is the impact of the pandemic on various health services and health outputs and outcomes?</p> <p>11. What are the adaptive actions that are taken along the way?</p>	<p>8. Which among these components/activities did not work in terms of screening, testing, treatment, and notification? Why?</p> <p>9. What are the key facilitating and hindering factors for each of those mentioned in number 7 and 8?</p> <p>10. What motivated facilities to adopt FAST Plus?</p> <p>11. What advocacy/promotion mechanisms worked, and what did not work?</p> <p>12. What behavior change communication initiatives prompted chest X-ray screening and treatment enrollment in hospitals implementing FAST Plus?</p> <p>13. What are the key facilitating and hindering factors for the intervention?</p> <p>14. What is the impact of the pandemic on various health services and health outputs and outcomes</p> <p>15. What are the adaptive actions that are taken along the way?</p>
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Replicability

<p>For TBIHSS and TB Platforms</p> <p>12. What is FAST Plus's potential applicability/replicability to health facilities outside the FAST Plus intervention sites?</p> <p>13. What facilitating factors would lead to success – including the potential for sustainability and scale up – in the Philippine setting?</p> <p>14. What factors might hinder scale-up and expansion of FAST Plus?</p> <p>and TB Platforms</p>	<p>For hospitals/health care facilities</p> <p>N/A</p>
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Systems and Context

<p>For TBIHSS and TB Platforms</p> <p>15. On a programmatic level and based on the health facilities you handle, what are structures, systems, and contextual factors related to governance, service delivery, financing,</p>	<p>For hospitals/health care facilities</p> <p>16. In your facility, what structures, systems, and contextual factors related to governance, service delivery, financing, sustainability, and regulation affect FAST Plus implementation?</p>
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sustainability, and regulation that affect FAST Plus implementation?	
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